STARK OPENING REMARKS AT MEDICARE ADVANTAGE HEARING

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"GAO’s findings raise serious questions about the value of lavishing subsidies onto MA plans as a means to “help” Medicare beneficiaries. Today’s second panel will reveal what is happening to Medicare beneficiaries in the real world as they attempt to navigate the confusing world of Medicare Advantage."

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WASHINGTON – Representative Pete Stark (D-CA), Chairman of the Ways and Means Health Subcommittee, prepared the following opening remarks for today's hearing on Medicare Advantage.

“I’d like to thank everyone for joining us today for an important oversight hearing to investigate the value of Medicare Advantage Overpayments.

“We are now overpaying Medicare Advantage plans 13% on average according to MEDPAC’s latest analysis. In some areas, we are overpaying by more than 50%.

“The President has just sent up a budget with more than a half trillion dollars of cuts to Medicare over the next decade. But, those cuts don’t come from Medicare Advantage. Those overpayments remain firmly in place.

“The President also just sent Congress his legislative response to the so-called Medicare trigger. Again, the President’s plan protects the special interests of the Medicare Advantage plans and puts all the costs of meeting what I think is an irresponsible trigger policy squarely on the backs of America’s seniors by increasing prescription drug premiums for millions of beneficiaries.

“Clearly, the Administration believes that these overpayments are warranted. We asked the Government Accountability Office (GAO) to report back to us regarding to what extent these overpayments translate into reduced cost-sharing or extra benefits, and, if so, whether this is an efficient way to achieve those goals. This report was requested jointly by Committees on Ways and Means, Energy and Commerce, and Government Reform and Oversight.

“I don’t want to steal GAO’s thunder, but think it’s worth highlighting a few things from the new report that we will discuss today:

“1) First, we have no idea what beneficiaries actually receive in MA plans because there is absolutely no requirement that MA plans turn over ANY DATA on services actually rendered to the government or to beneficiaries. The only way GAO could analyze the different benefits was to rely on projections from the MA plans with respect to how they said they’d spend their subsidies. That is not is acceptable. That is just like no-bid contracts in Iraq. We ought to know what we’re getting and it would be simple for CMS to request that data.

“2) Second, looking at the MA plans own projections, GAO finds that beneficiaries can spend MORE in MA plans than they would in fee- for-service Medicare. The services most often associated with higher copayments are home health and hospitalizations – two services that are vital to sick people and are obviously more of a burden to low-income people. If plans successfully cherry-pick healthy seniors, which they do, and the payments are based on averages, it means we’re overpaying them even more than we think!

“3) Third, MA plans only invest 3% in Part B premium reductions. Frankly, that’s the only “improvement” that is guaranteed to be valuable to every enrollee.

“4) Foruth, MA plans are far less efficient than fee-for-service Medicare, which essentially operates with a 98% Medical Loss Ratio. In contrast, the average MA plan MLR is 87%. But nearly one-third have MLRs of less than than 85%. It would be good to know how low the MLRs actually go, but CMS has actually refused to release this data to GAO. My hope is that they change their minds.

“GAO’s findings raise serious questions about the value of lavishing subsidies onto MA plans as a means to “help” Medicare beneficiaries. Today’s second panel will reveal what is happening to Medicare beneficiaries in the real world as they attempt to navigate the confusing world of Medicare Advantage. Our witnesses will confirm that many Medicare beneficiaries enroll in these plans unaware that their costs may be higher than what they would face in traditional Medicare. They believe that they are enrolling in a Medigap plan, under which they would never pay more, and are shocked when they learn how much they have to pay.

“Clearly, these issues are only a small part of the oversight needed into MA plans. I’d be remiss not to highlight that the CHAMP Act -- which we passed out of the House last year and is still pending in the Senate – addressed many of these concerns. It leveled the playing field on payments to Medicare Advantage plans, it required plans to meet a Medical Loss Ratio of 85% to participate in the program, it ensured that beneficiaries wouldn’t pay more in MA than in traditional Medicare, and it provided states with the tools they need – and the federal government refuses to use – to regulate marketing of Medicare Advantage plans.

“I’m not against private plans in Medicare – my district has one of the highest penetrations of Medicare Advantage. I believe people should have the choice to join a private plan. But, the rest of us should not be subsidizing that choice. Plans should compete on a level playing field and preserve many of the core choices that really matter to beneficiaries – choice of doctor and hospital. I see no reason why managed care plans should be grossly overpaid and under-regulated."